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ABSTRACT

This report recommends that the Social Security Act Title XIX be amended to include a 24-month extension of Medicaid to families who become ineligible for cash assistance under the Aid to Families with Dependent Children (AFDC) program. This amendment accompanies the Family Welfare Reform Act of 1987 (H.R. 1720), which is proposed to replace the AFDC program of the Social Security Act Title IV. The objectives of the amendment are the following: (1) encourage former AFDC recipients to work and to remain working; (2) reduce the number of working poor families with no health care coverage; and (3) complement and encourage existing State efforts to make health care coverage available to the uninsured. The loss of Medicaid coverage is a major obstacle to working for women with children on AFDC. Under the current law, Medicaid coverage may vary from 4 to 15 months depending on the income a family was earning at the time it lost AFDC cash benefits. The amendment also requires States to extend coverage for six months to families who lose AFDC benefits as a result of child or spousal support. A cost estimate and an inflationary impact statement are included. The proposed amendment is supported by various committees and legislators. Dissenting views express concern that the proposed extension will encourage increased dependence on welfare, and discourage employers from offering health care benefits. (FMW)

12-6-88

100TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPT. 100-159
Part 3

ED301617

FAMILY WELFARE REFORM ACT OF 1987

SEPTEMBER 15, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

ADDITIONAL AND DISSENTING VIEWS

[To accompany H.R. 1720 which on March 19, 1987, was referred to the Committee on Ways and Means, and in addition referred to the Committee on Education and Labor for consideration of such provisions of title I of the bill as fall within the jurisdiction of that committee under clause 1(g), rule X, and the Committee on Energy and Commerce for consideration of such provisions of title IV of the bill as fall within the jurisdiction of that committee under clause 1(h), rule X]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1720) to replace the existing AFDC program with a new Family Support Program which emphasizes work, child support, and need-based family support supplements, to amend title IV of the Social Security Act to encourage and assist needy children and parents under the new program to obtain the education, training, and employment needed to avoid long-term welfare dependence, and to make other necessary improvements to assure that the new program will be more effective in achieving its objectives, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment (stated in terms of the page and line numbers of the introduced bill) is as follows:

Page 46, strike line 12 and all that follows through page 47, line 22, and insert in lieu thereof the following (and conform the table of contents accordingly):

TITLE IV—TRANSITIONAL MEDICAID SERVICES FOR FAMILIES

SEC. 401. MEDICAID ELIGIBILITY.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by redesignating section 1921 as section 1922 and by inserting after section 1920 the following new section:

"EXTENSION OF MEDICAID BENEFITS

"SEC. 1921. (a) INITIAL 6-MONTH EXTENSION.—

"(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from employment of the caretaker relative (as defined in subsection (e)), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

"(2) NOTICE OF BENEFITS.—Each State, in the notice of termination of aid under part A of title IV sent to a family meeting the requirements of paragraph (1)—

"(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

"(B) shall include a card or other evidence of the family's entitlement to assistance under this title for the period provided in this subsection.

"(3) TERMINATION OF EXTENSION.—

"(A) NO DEPENDENT CHILD.—Subject to subparagraph (B), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child who is (or would if needy be) a dependent child under part A of title IV; except that, with respect to a child who would cease to receive medical assistance because of this subparagraph but who may be eligible for assistance under the State plan because the child is described in clause (i) or (v) of section 1905(a), the State may not discontinue such assistance under this subparagraph until the State has determined that the child is not eligible for assistance under the plan.

"(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

"(4) SCOPE OF COVERAGE.—

"(A) IN GENERAL.—Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of title IV.

"(B) STATE MEDICAID 'WRAP-AROUND' OPTION.—A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by a employer of the caretaker relative or the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

"(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection, to make application for such employer coverage, but only if—

"(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

"(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

"(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1902(a)(25)).

Payments for coverage under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

"(b) MANDATORY 18-MONTH EXTENSION.—

"(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B), in the last month of the period the option of extending coverage under this subsection for the succeeding 18-month period, subject to paragraph (3).

"(2) NOTICE OF OPTION.—

"(A) IN GENERAL.—Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for subsequent extended assistance under this subsection. Each such notice shall include (i) a statement as to whether any premiums are required for such extended assistance, and (ii) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D).

"(B) REPORTING OF EARNINGS REQUIRED TO DETERMINE ANY PREMIUM.—If the State requires a premium for extended assistance under this subsection, the State may require (as a condition for extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings (less the cost of day care for dependent children) in each of the first 3 months of that period; but such requirement shall only apply if the notice under subparagraph (A) during the 3rd month of assistance describes the requirement of this subparagraph.

"(C) 6TH MONTH NOTICE.—The notice under subparagraph (A), furnished during the 6th month of assistance under this subsection, shall describe the amount of any premium required of a particular family for each of the first 3 months of extended assistance under this subsection.

"(3) TERMINATION OF EXTENSION.—

"(A) IN GENERAL.—Subject to subparagraphs (B) and (C), extension of assistance during the 18-

month period described in paragraph (1) to a family shall terminate (during the period) as follows:

"(i) NO DEPENDENT CHILD.—The extension shall terminate at the close of the first month in which the family ceases to include a child who is (or would if needy be) a dependent child under part A of title IV.

"(ii) FAILURE TO PAY ANY PREMIUM.—If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the individual has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

"(iii) QUARTERLY INCOME REPORTING AND TEST.—The extension shall terminate at the close of the 1st, 4th, 7th, 10th, 13th, or 16th month of the 18-month period if—

"(I) the family fails to report to the State, by the 21st day of such month, information on the family's gross monthly earnings (less the costs of day care for dependent children) in each of the previous 3 months, unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis; except that this subclause shall not apply unless the State has notified the family, in the month before the month in which information is required to be reported under this subclause, of the reporting requirement of this subclause;

"(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

"(III) the State determines that the family's average gross monthly earnings (less costs of day care for dependent children) during the immediately preceding 3-month period exceeds 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

Instead of terminating a family's extension under clause (I), a State, at its option, may

provide for suspension of the extension until the month after the month in which the family reports information required under that subclause, but only if the family's extension has not otherwise been terminated under subclause (II) or (III).

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information provided under section 402(a)(9). The State shall make determinations under clause (iii)(III) for a family each time a report described in clause (iii)(I) for the family is received.

"(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan.

"(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—

"(i) DEPENDENT CHILDREN.—With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) or (v) of section 1905(a), the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

"(ii) MEDICALLY NEEDY.—With respect to an individual who would cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1902(a)(10)(C) (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

"(4) COVERAGE.—

"(A) IN GENERAL.—During the extension period under this subsection—

"(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under

the plan approved under part A of title IV; and

"(ii) the State plan may offer alternative coverage described in subparagraph (D).

"(B) ELIMINATION OF MOST NON-ACUTE CARE BENEFITS.—At a State's option and notwithstanding any other provision of this title, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) of section 1905(a).

"(C) STATE MEDICAID 'WRAP-AROUND' OPTION.—At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to 'wrap-around' coverage) for families electing medical assistance under this subsection in the same manner as such option applies to families provided extended medical assistance under subsection (a).

"(D) ALTERNATIVE ASSISTANCE.—At a State's option, instead of the medical assistance otherwise made available under this subsection the State may offer families a choice of health care coverage under one or more of the following:

"(i) ENROLLMENT IN FAMILY OPTION OF EMPLOYER PLAN.—Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

"(ii) ENROLLMENT IN FAMILY OPTION OF STATE EMPLOYEE PLAN.—Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

"(iii) ENROLLMENT IN STATE UNINSURED PLAN.—Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

"(iv) ENROLLMENT IN HMO.—Enrollment of the caretaker relative and dependent children in a health maintenance organization (as defined in section 1903(m)(1)(A)) less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with re-

spect to receiving services through a health maintenance organization in accordance with section 1903(m).

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) shall be considered, for purposes of section 1903(a)(1), to be payments for medical assistance.

"(E) OPEN ENROLLMENT.—If a State offers an alternative option under subparagraph (D) to families, the State must offer such families the option of enrolling or disenrolling in such an option during a one month period each year without cause and, in the case of enrollment under clause (iii) or (iv) of such subparagraph, the option of disenrolling from the organization of plan for cause at any time.

"(F) PROHIBITION ON COST-SHARING FOR MATERNITY AND PREVENTIVE PEDIATRIC CARE.—

"(i) IN GENERAL.—If a State offers an alternative option under subparagraph (D) for families, under the option the State must assure that care described in clause (ii) is available without charge to the families through—

"(I) payment of any deductibles, coinsurance, or other cost-sharing respecting such care, or

"(II) providing coverage under the State plan for such care without any cost-sharing, or any combination of such mechanisms.

"(ii) CARE DESCRIBED.—The care described in this clause consists of—

"(I) services related to pregnancy (including prenatal, delivery, and postpartum services), and

"(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1905(a)(4)(B)) for each child who meets the age and date of birth requirements to be a qualified child under section 1905(n)(2).

"(5) PREMIUM.—

"(A) PERMITTED.—Notwithstanding any other provision of this title (including section 1916), a State may impose a premium for a family for ex-

tended coverage under this subsection, which premium may vary by family size.

"(B) LEVEL MAY VARY BY OPTION OFFERED.—The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(C).

"(C) LIMIT ON PREMIUM.—In no case may the amount of any premium under this paragraph for a family for a month in one of the premium payment periods described in subparagraph (D)(ii) exceed 10 percent of the amount by which—

"(i) the family's average gross monthly earnings (less the costs of day care for dependent children) during the premium base period (as defined in subparagraph (D)(iii)), exceeds

"(ii) the monthly minimum wage earnings (as defined in subparagraph (D)(i)) for the period.

"(D) DEFINITIONS.—In subparagraph (C):

"(i) The term 'monthly minimum wage earnings' means the average amount of earnings which one person would earn during a month in the period if the person were employed for 8 hours on each weekday in the month and was paid the minimum wage rate provided under section 6(a) of the Fair Labor Standards Act of 1938.

"(ii) A 'premium payment period' described in this clause is a 3-month period beginning with the 1st, 4th, 7th, 10th, 13th, or 16th month of the 18-month extension period provided under this subsection.

"(iii) The term 'premium base period' means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

"(c) APPLICABILITY IN STATES AND TERRITORIES.—

"(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a), the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(2) INAPPLICABILITY IN COMMONWEALTHS AND TERRITORIES.—The provisions of this section shall only apply to the 50 States and the District of Columbia.

"(d) GENERAL DISQUALIFICATION FOR FRAUD.—This section shall not apply to an individual who is a member of a family if the individual's eligibility for aid was terminated because of fraud or the imposition of a sanction.

"(e) CARETAKER RELATIVE DEFINED.—In this section, the term 'caretaker relative has the meaning of such term as used in part A of title IV.".

(b) CONFORMING AMENDMENTS.—(1) Section 1902(e)(1) of such Act (42 U.S.C. 1396a(e)(1)) is amended by striking "Notwithstanding" and all that follows through the end and inserting the following: "For provision relating to extension of coverage for certain families which have received aid pursuant to a State plan approved under part A of title IV and which have earned income, see section 1921.".

(2) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended by striking "or" at the end of clause (vii), by inserting "or" at the end of clause (viii), and by inserting after clause (viii) the following new clause:

"(ix) individuals provided extended benefits under section 1921,".

(c) WAIVER.—Upon approval of the demonstration project relating to the Family Independence Program in the State of Washington under section 807 of this Act (as added by the amendment reported by the Committee on Ways and Means to H.R. 1720) and with respect to such project, the Secretary of Health and Human Services shall waive compliance with any requirements of sections 1902(a)(1) 1916, and 1921 of the Social Security Act, but only to the extent necessary to enable the State to carry out the project as enacted by the State of Washington in May 1987.

SEC. 402. EXTENSION DUE TO COLLECTION OF CHILD OR SPOUSAL SUPPORT.

(a) IN GENERAL.—Section 1902(e)(1) of the Social Security Act (42 U.S.C. 1396a(e)(1)) is amended by inserting "(A)" after "(e)(1)" and by adding at the end the following new subparagraph:

"(B) Notwithstanding any other provision of this title, each dependent child, and each relative with whom such a child is living (as such terms are defined in part A of title IV, and including the spouse of such a relative as described in section 406(b)), who—

"(i) becomes ineligible for aid under part A of title IV as a result (wholly or partly) of the collection or increased collection of child or spousal support under part D of such title, and

"(ii) has received such aid in at least three of the six months immediately preceding the month in which such ineligibility begins,

shall be deemed, for purposes of this title, to be a recipient of aid under part A of title IV for an additional 6 calendar months beginning with the month in which such ineligibility begins.".

(b) CONSTRUCTION.—Section 1902(h) of such Act (42 U.S.C. 1396a(h)) is amended by inserting "(1)" after "(h)" and by adding at the end the following new paragraphs:

"(2) Nothing in section 417(a)(1) shall be construed as requiring or authorizing a case manager assigned under such section to conduct any activities with respect to medical assistance furnished (or which may be furnished) under this title.

"(3) Any individual who would be receiving aid under part A of title IV but for section 417(b)(1)(A) shall be considered, for purposes of this title, to be receiving such aid.".

SEC. 403. EFFECTIVE DATE.

(a) IN GENERAL.—The amendments made by this title shall apply (except as provided under subsection (b)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1988 (without regard to whether regulations to implement such amendments are promulgated by such date), with respect to families that cease to be eligible for aid under part A of title IV of the Social Security Act on or after such date.

(b) DELAY.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this title, the State plan shall not be regarded as failing to comply with the requirements of title XIX of such Act solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

PURPOSE AND SUMMARY

The Committee amendment to H.R. 1720 has three basic purposes. First, the amendment is intended to encourage families receiving both Medicaid and cash assistance under the Aid to Families with Dependent Children (AFDC) program to work and to remain at work. The amendment would assure continued Medicaid or alternate health care coverage for these mothers and children for 24 months from the time they lose AFDC benefits because of earnings or increased hours of employment, so long as they continue working. Secondly, the amendment is intended to reduce the number of working poor families with no health care coverage. Finally, the amendment is designed to complement and encourage existing State efforts to make health care coverage available to the uninsured.

During FY 1988, the Committee amendment will provide health care coverage to about 475,000 working poor families, including roughly 950,000 children, according to estimates supplied by the Congressional Budget Office.

By providing extended Medicaid coverage to families who leave the cash assistance rolls and continue to work, the Committee amendment will result in additional Federal outlays. These outlays

are assumed by the Budget Resolution for FY 1988, H. Con. Res. 93, which provides a total of $2.4 billion in new entitlement authority for several Medicaid initiatives during the three year period FY 1988–FY 1990, including an initiative to address the needs of working welfare recipients.

The Committee amendment would not impose any requirements on employers or insurers. While the Committee amendment would allow the States, with Federal Medicaid matching funds, to purchase employer group health coverage on behalf of former AFDC families for a limited period of time, the amendment does not require employers to offer health care coverage and does not impose minimum specifications relating to any coverage they might choose to offer.

The Family Welfare Reform Act, H.R. 1720, was jointly referred to the Committee on Energy and Commerce for consideration of the provisions of title IV of the bill, relating to transitional Medicaid coverage for families. The Committee amendment affects only this title of H.R. 1720. The Committee has not considered, and makes no recommendations regarding, the remaining titles of H.R. 1720.

The Committee notes that the Committee on Ways and Means, which does not have jurisdiction over the Medicaid program, has recommended that States be required to extend Medicaid benefits for a 6 month period to those families that leave welfare with earnings. In this Committee's view, the Ways and Means Committee's recommendation is at once overly broad and overly restrictive. It is overly broad because it would extend Medicaid coverage to those working recipients who lose AFDC benefits not because they earn too much, but because they marry and therefore lose their categorical eligibility for benefits. It is overly restrictive because it would extend the current Medicaid benefit for most recipients by only 2 months, and because for some recipients it would actually reduce the coverage available under curent law from 9 (or, in some States, 15) months. Six months is not a sufficient amount of time for most former welfare recipients to work their way into a job that offers affordable health care coverage for them and their children. The work disincentive under current law resulting from the loss of Medicaid eligibility after 4 months would not be significantly reduced.

Background and Need for the Legislation

Women with children on AFDC face a major work disincentive under current law. As long as they continue to receive a cash payment under AFDC, they are automatically eligible to receive Medicaid coverage for themselves and their children. However, if they go to work, or increase their hours at work, and earn enough to lose cash assistance, they will lose their Medicaid coverage as early as four months later—whether or not their employer offers health care coverage, whether or not they can afford the coverage that their employer offers, and whether or not whatever coverage they can afford is adequate. Unlike the AFDC or Food Stamp programs, Medicaid benefits to working families do not phase down gradually

as earnings increase; instead, they terminate abruptly. Economists often refer to this disincentive as the Medicaid "cliff" or "notch."

While there is general agreement that the abrupt loss of Medicaid benefits is a work disincentive, there is not much agreement on how strong this disincentive is in the aggregate. The Congressional Budget Office provided the following illustration of the Medicaid notch in one hypothetical case:

> . . . consider an AFDC mother with one child whose countable income is $4,200 in a State with a payment level of $4,800, and no medically needy program. If she works longer hours and her countable income increases by $50 per month, she will eventually lose $50 per month in cash assistance. In addition, she will lose Medicaid benefits that cost an average of $150 per month to provide. For this working mother, the implicit "tax rate" on the increase in her earnings is 400 percent. [This "tax rate" represents a loss of $200 ($50 from AFDC and $150 from Medicaid) resulting from an increase in earnings of $50—and 200/50=400 percent].

While not every AFDC mother faces a 400 percent "tax rate" for returning to work, it is evident that the loss of Medicaid coverage can discourage these women from working, particularly if their only employment opportunities are low-paying jobs that do not offer health insurance coverage and if they or their children have serious health care needs.

Despite the disincentive, many AFDC mothers do go to work. If her employer does not offer health benefits, or if she cannot afford the monthly premiums, she and her children will be uninsured. This makes it extremely difficult for the family to have access to needed health care services, and it exposes the family to the risk of financial catastrophe. The Subcommittee on Health and the Environment heard from a mother of three who had found a job, left public assistance, and was in the third month of her four-month Medicaid transition coverage. She testified:

> Now that I am losing my Medicaid, I will have no health care coverage. My employer does have health insurance that I can buy; however, I cannot afford the $118 a month for the coverage. In addition to the monthly fee, the insurance plan would require me to pay a yearly $100 deductible plus 20 percent of the first $3500 of expenses. The plan would also require me to pay $3 for each prescription. Compared to Medicaid, this plan covers fewer services. Dental and eye care are not covered at all, for example.
>
> I receive $502.68 every two weeks in salary. From that I must pay my rent of $345 per month, $400 per month for food, $60 per month at the laundromat, and $100 or more for my car which is not in the best shape. I must have a car to keep my current job. That leaves me about $50 per month for my telephone and other expenses to maintain a household and care for and clothe three teenage girls and myself.

> I simply cannot afford to pay $118 a month plus all the other costs for health insurance that covers less than my Medicaid covers.
>
> You may ask what will happen to us, if we need health care? What would I do if my daughter has another asthma attack? I would make sure I got her the medical care she needs and in so doing I would make a lot of bills I couldn't pay. Then I'd probably have collection agencies after me and get my wages garnished.

About 37 million Americans have no public or private health insurance coverage at some point during the year. According to the Employee Benefit Research Institute, the overwhelming majority of the uninsured—roughly 87 percent—live in families where someone works either full-time or part-time. More than half (52 percent) live in families where the principal earner is a full-time, steadily-employed worker. Working families, and especially working poor families, lack health care coverage primarily because low-wage employers often do not offer coverage, the family can't afford it after rent, food, commuting, child care, and other essential expenses are met.

Mothers and children leaving welfare represent a significant portion of the uninsured. Roughly half a million families leave AFDC each year because of increased earnings or increased hours of work. (In FY 1986, roughly 3.7 million families received AFDC benefits, and therefor Medicaid. This population included about 7.3 million children, as well as some 3.7 million adults, mostly mothers). These families, normally headed by young, single, poorly-educated women with few job skills and little prospect for immediate employment in a firm that offers good fringe benefits, are at great risk for being uninsured. According to CBO, studies indicate that only about half of all unmarried women losing AFDC benefits and Medicaid due to increased earnings have private health insurance coverage. A 1985 study by the General Accounting Office found that, within a year of losing AFDC and Medicaid after returning to work, 50 percent of former AFDC families were completely uninsured; the comparable rate for the non-elderly population in general was 17.4 percent. The lower the woman's hourly wages, the greater the likelihood that she and her children will be uninsured after losing AFDC and Medicaid.

The loss of Medicaid coverage, and the lack of any employer group coverage, dramatically reduces the use of medical care by low-income families. Available data, according to CBO, suggest that low-income families without health insurance are 38 percent less likely to use physician services and 71 percent less likely to use hospital services than are low-income families eligible for Medicaid. Yet low-income children are more likely than their higher income counterparts to have worse health and more chronic or serious illnesses. The lack of health care coverage jeopardizes the health of working poor mothers and their children; serious medical conditions may go undetected or untreated, and preventive services may well be delayed or foregone.

In short, former AFDC families that work their way off welfare have the greatest need for health care coverage, because they are

least able to pay for services out of pocket and because their health is more likely to be poor. Yet these are precisely the families that, under current law, are among those most likely to be uninsured.

A number of States have begun to address the needs of the uninsured by implementing programs that will reduce the number of workers without health care coverage. According to the National Governors' Association, at least three States—Maine, Michigan, and Washington—are attempting to develop "affordable health plan structures" that not only delay the loss of Medicaid benefits for working AFDC families, but also provide a transition to longer-term health coverage for poor and near-poor working families alike. In addition, the Robert Wood Johnson Foundation, through its Health Care for the Uninsured Program, has funded 15 projects throughout the country to develop insurance products for small employers that do not now offer health insurance coverage to their employees and dependents.

In the view of the Committee, efforts to make AFDC families economically self-sufficient must address the consequences of the loss of Medicaid coverage. Without extended Medicaid coverage to ease the transition from welfare to work, AFDC families will continue to face strong disincentives to work, a great likelihood of being uninsured once they leave welfare, and high financial barriers to needed physician and hospital care. We as a Nation cannot afford, in the name of "welfare reform," to add large numbers of working poor women and children to the ranks of the uninsured. The costs of such a policy to the health of low-income women and children are simply unacceptable.

Explanation of Legislation

CURRENT LAW

Under current law, States must provide Medicaid benefits to families with dependent children who receive cash assistance under the AFDC program. About half the States offer AFDC benefits to children in two-parent families where one of the parents is unemployed. To receive AFDC payments, a family must have a gross income that does not exceed 185 percent of the State-established need standard. In addition, the family's counted income must be below the State established AFDC payment standard (which in nearly 30 States is below the State's AFDC need standard). As of December, 1986, the average Medicaid eligibility standard for a mother and two children—which is a function of each State's AFDC payment standard—was 49 percent of the Federal poverty level, ranging from 15 percent of poverty in Alabama to 91 percent of poverty in Utah.

To encourage AFDC families to work, current law does not count, or disregards, certain earned income in determining the level of payments, if any, a family can receive. In addition to disregarding work expenses (up to $75 per month) and child care costs (up to $160 per month per child), current law disregards the first $30 in monthly earnings plus one-third of remaining earnings. These so-called "earned income disregards" are time-limited, however; after the first 4 months of work, the one-third of remaining

earnings are no longer disregarded, while the initial $30 continues to be disregarded for a total of 12 months.

If a family has received AFDC benefits in at least 3 of the 6 months in which the family becomes ineligible for AFDC because of increased income from, or increased hours of, employment, the family is entitled to continued Medicaid coverage for 4 months, beginning with the month in which the family became ineligible for AFDC. (Section 1902(e)(1) of the Social Security Act). Thus, if a family loses AFDC eligibility because its countable income exceeds the payment standard after disregarding $30 plus one-third of the remaining earnings, it is entitled to 4 months of continued Medicaid coverage.

If a family loses eligibility for AFDC payments because the disregard of one-third of the remaining earnings is no longer available to it after 4 months, or because the first $30 disregard is not available to it after 12 months, States must extend Medicaid coverage for 9 months from the month in which the family lost AFDC. States may, at their option, expand this 9-month mandatory coverage period to a total of 15 months for this group of families. (Section 402(a)(37) of the Social Security Act). Thus, unlike the families who qualify for the mandatory 4-month Medicaid extension, families that qualify for 9 months (and in some States, up to 15 months) of extended Medicaid coverage lose AFDC eligibility because they no longer have the benefit of the $30 or the one-third disregards, not because their earned income is so high that even if they had the benefit of the disregards they would not receive AFDC.

The following examples illustrate the effect of current law. Assume a State with an AFDC need standard of $478 per month and an AFDC payment standard of $345 per month for a mother and two children (this would give the State a rank of 28th in cash benefits levels). The mother takes a 40-hour per week job at $4.00 an hour; the job does not offer health insurance. She has child care costs after school of $80 per month for each child, and work-related expenses other than child care of $75 for the month, but has no income other than earnings and AFDC. She continues her AFDC benefits in the first month of full employment. Her gross earnings of $688 (based on an average of 4.3 weeks in a month) are less than 185 percent of the need standard, or $884. Her countable income—$688 gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $423, or $141)—is $282, which is less than the payment standard of $345 per month. She and her children will continue to receive Medicaid coverage on the basis of her receipt of cash assistance.

Assume next that after some time on the job, the mother receives a raise to $4.25 per hour, and that she continues to work 40 hours per week. She would continue to receive her AFDC benefits in the first four months of full employment at this new wage. Her gross income of $731 (based on an average of 4.3 weeks in a month) is still under 185 percent of the need standard. Her countable income—$731 gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $466, or $155)—is $311, which is less than the AFDC payment standard of $345. After the fourth month of working full-time at $4.25 per hour, however, the one-third remaining earned income

disregard is no longer applied in determining her countable income. At that point, she becomes ineligible for AFDC benefits, because her monthly countable income is $466, or more than the $345 AFDC payment standard. She will be entitled to receive Medicaid coverage for 9 months, because she lost AFDC due to the expiration of an earned-income disregard. After this 9-month extension coverage, she and her children will be uninsured.

Finally, assume the mother's raise is to $4.75 per hour rather than $4.25. She would lose her AFDC cash assistance in the first full month of employment at this new wage level. Her gross monthly earnings of $817 (assuming an average of 4.3 weeks in a month) are still under 185 percent of the State's need standard. However, her countable income—$817 gross monthly earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $552, or $184)—is $368, or $23 over the State's AFCD payment standard. She would then be entitled to extended Medicaid coverage for 4 months, because she lost AFDC even after the application of both the $30 and one-third earned income disregards. After this 4-month extension coverage, she and her children will be uninsured. Note that by increasing her raise by 50 cents per hour—from $4.25 to $4.75—she has in effect lost 5 months of extended Medicaid coverage.

Of course, where State AFDC payment standards are lower than $345 per month for a family of 3, the family in this case would find itself ineligible for AFDC, and therefore Medicaid, much earlier at the same levels of earnings. For instance, assume the State sets its AFDC need standard at $518 per month and its AFDC payment standard at $259 per month for a family of 3. If the mother starts a full-time job at $4.00 per hour, she would be ineligible for AFDC benefits after the first full month of employment. Although her gross earnings of $688 would not exceed 185 percent of the State payment standard, her countable income—$688 in gross earnings, less work-related expenses ($75), less child care ($160), less the earned income disregard ($30 plus one-third of $423, or $141)—would be $282, which exceeds the $259 payment standard. After losing her AFDC benefits, she and her children would receive extended Medicaid coverage for 4 months, and then we uninsured. If the AFDC payment standard were set at $346, as in the example above, she and her family would continue to receive AFDC and Medicaid at this level of earnings.

Finally, current law requires mothers receiving AFDC to assign their rights to child support to the State and to cooperate with the State in establishing the paternity of a child born outside of marriage and in obtaining support payments from the father. Families who become ineligible for AFDC payments as a result of the collection of child or spousal support, and who have received AFDC in at least 3 of the 6 months prior to becoming ineligible, are entitled to Medicaid coverage for an additional 4 months after losing AFDC eligibility. (Section 406(h) of the Social Security Act).

After the mandatory or optional Medicaid extension coverage expires, these families may potentially qualify for Medicaid as "medically needy" beneficiaries. However, this would be an option only in States which have elected to offer Medicaid coverage to the "medically needy," and only if the family has incurred medical ex-

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penses that, when applied against the family's income, are sufficient to reduce the income to below the State-established medically needy income level.

EXTENSION OF MEDICAID COVERAGE DUE TO WORK

The Committee amendment would require States to extend Medicaid coverage for a total of 24 months to families who become ineligible for cash assistance because of earnings, and who, during the 24-month period, continue to work. In contrast to current law, the duration of Medicaid coverage would not vary from 4 months to 9 months to 15 months depending upon the income a family was earning at the time it lost AFDC benefits and the State in which it resides. Instead, all otherwise qualified families who lose cash assistance due to earnings would be entitled to 24 months of continued Medicaid coverage.

During the first 6 months of this extension, States would have to offer the same Medicaid benefits to these families as they offer to those receiving AFDC. During the next 18 months, States would have to continue offering Medicaid coverage, but they could also offer alternate types of coverage, and they could require families to pay an income-related monthly premium for whatever coverage the families elected. The provision would be effective for those families losing AFDC benefits due to earnings on or after January 1, 1988, and would apply apply to all the States, including Arizona, which currently operates its Medicaid program under a waiver. Individuals whose AFDC benefits were lawfully terminated because of fraud, or who were lawfully subject to sanction under the AFDC program, could not qualify for any extended coverage under the bill.

Initial 6-Month Extension of Coverage.—Under the Committee amendment, States would be required to extend Medicaid coverage for an initial period of 6 months to families who lose eligibility for AFDC because of hours of, or income from, employment of the caretaker relative (usually the mother), and who received cash assistance in at least 3 of the 6 months immediately preceding the month in which the family lost AFDC benefits. These months need not be consecutive. The Committee notes that the mother or other caretaker need not have earnings in the month prior to the month in which she receives continued Medicaid coverage; she can begin working and begin receiving extended Medicaid coverage in the same month. The Committee also notes that the reason for the loss of eligibility must be hours of, or income from, employment of the mother or other caretaker relative. Thus, extended Medicaid coverage would be available to families who lose AFDC benefits because the AFDC earned income disregards no longer apply due to durational limitations; to families who are ineligible for AFDC benefits even after application of the AFDC earned income disregards; and to families who lose AFDC benefits because of the application of the 185 percent gross income limit. Extended Medicaid coverage would also be available to families who lose AFDC in part because of an increase in hours of, or income from, employment, and in part because of an increase in unearned income. Thus, a woman who loses AFDC in part because her hours of employment increase

and in part because she begins to receive Social Security survivors' benefits would be considered to have lost AFDC due to earnings and would be entitled to extended Medicaid coverage for herself and her children.

The Committee amendment clarifies that families eligible for the initial 6-month Medicaid extension coverage are automatically entitled to continued coverage and need not reapply for benefits. This automatic extension of coverage is implicit in the 4- and 9-month Medicaid transition periods under current law. However, the Committee understands that, in a number of States, persons eligible for either the 4- or 9-month coverage periods are terminated from Medicaid upon loss of AFDC benefits and instructed to reapply for Medicaid. Not only is this practice inconsistent with current law, but it has the practical effect of leaving working mothers and their children without any Medicaid coverage. In one State, according to testimony received by the Health and the Environment Subcommittee, over 25,000 families leave AFDC each year due to employment, while only about 3,500, or less than 15 percent, receive extended Medicaid coverage in any given month. The purpose of the automatic extension provision in the Committee bill is to avoid such outcomes.

To assure that those families eligible for extended Medicaid benefits actually receive coverage, the Committee amendment requires each State, in its written notice of termination of AFDC benefits to families losing eligibility due to employment, to include the Medicaid card or other evidence of entitlement which establishes the family's eligibility for the entire 6-month period. In those States which do not issue cards, the evidence of entitlement must be acceptable to providers and sufficient to enable them to submit clean claims for reimbursement for covered services. The notice would also have to inform the family of its right to this extended coverage and of the grounds on which eligibility for benefits during this 6-month period may be terminated. The Committee notes that it is the practice of some States to notify families by letter that they are eligible for Medicaid without promptly providing them with a Medicaid number or other evidence of coverage that will enable them to obtain services from a provider. This practice does not satisfy the current law requirement that States make Medicaid coverage promptly available to eligibile individuals, and it would not meet the requirements under the Committee amendment. The Committee intends that there be no interruption in Medicaid coverage for these working women and their children who lose AFDC benefits due to employment.

Under the Committee amendment, a State may terminate Medicaid coverage during the 6-month extension only because the family no longer includes a child who is (or would if needy be) a "dependent child" as defined under the AFDC program. However, the State may not discontinue the child's coverage in these cases until it has first made a determination that the child fails to qualify for assistance on the basis of any other eligibility category under the State's Medicaid plan. For example, in a State that covers all financially needy children under age 21, a child who turns 18 and ceases to be a "dependent child" would still (if financially needy) be eligible for Medicaid as a financially needy child. In such a case, the coverage

of the mother or other caretaker relative would terminate, but the child's eligibility would continue without interruption. The amendment specifies that no termination may take effect until the State has given the family written notice of the grounds for termination and, as under current law, has informed the beneficiary of his or her right to a pretermination fair hearing.

During the initial 6-month extended coverage period, States would be required to offer eligible families Medicaid benefits of the same amount, duration, and scope as those furnished to cash assistance recipients. The State would not be permitted to charge the family a premium for coverage during this period. A State could, however, elect to offer Medicaid "wrap around" coverage to those families where the employer of the caretaker relative offered group health insurance coverage to its employees. The State would then treat the employer's group coverage as a third party liability, and pay only the amounts remaining after the employer's plan had paid the hospital, physician, or other provider. As under current law, in the case of prenatal or preventive pediatric care, the State would be required to pay the provider first, and then seek reimbursement from the employer's plan.

Under this Medicaid "wrap around" option, States could require the caretaker relative in the family, as a condition of the 6-month extended coverage, to apply for whatever group health coverage her employer offers. However, the State could not require her to contribute financially to such coverage, whether through payroll deductions cost-sharing, or otherwise. Instead, the State would have to pay the family's share of the premiums, as well as any deductibles, coinsurance, copayments, or other costs under the employer's health care coverage. These State expenditures would be subject to Federal Medicaid matching payments at the State's regular rate for services. The purpose of this "wrap around" option is to allow the State to replace its funds (and the Federal government's matching funds) with employer or insurer dollars for hospital, physician, or other services covered under the employer's health plan, while at the same time shielding the family from any cost-sharing or other financial expense which it would not incur under the State's Medicaid program. The Committee amendment does not require employers to offer health care coverage, and it does not specify how that coverage, if any, should be structured.

Subsequent 18-Month Extension of Coverage.—The Committee amendment would require States to extend Medicaid coverage for an additional 18 months to families who have received coverage throughout the initial 6 month extension period, so long as the family continues to have earnings and meets the reporting and other requirements. To assure that only working poor and near-poor families are eligible for coverage during this 18-month extension period, the amendment would exclude from coverage those families which earn more than 185 percent of the Federal poverty income guidelines for a family of their size (as issued and updated annually by the Department of Health and Human Services).

The State could, at its option, require families to pay a monthly premium for coverage during this 18-month period. The Committee recognizes that many of the families who leave welfare due to earnings initially find jobs that pay at the minimum wage level or

slightly above. At these income levels, even nominal premium requirements can be enormously burdensome, especially for larger families. The amendment would therefore limit the premiums that a State may impose to 10 percent of the amount by which the family's average gross monthly earnings, less the costs of day care for dependent children, exceed the amount that an individual could earn in a month by working at minimum wage ($3.35 per hour) for 8 hours a day, 5 days a week, for an average month of 4.3 weeks or $576 per month. Thus, if the former recipient worked 40 hours per week at $4.50 per hour, grossing $774 per month, and if she had child care expenses of $150, the maximum premium the State could impose for that month would be 10 percent of $624 minus $581, or $4.30.

Whether or not the State elects to impose a monthly premium, it would have to offer the family the option of continuing to receive Medicaid coverage throughout the 18-month period. This coverage would not have to be identical to that offered to AFDC recipients or to families during the initial 6-month coverage period. The State could elect not to offer some or all of the non-acute care services that it offers in its regular Medicaid benefit package, including skilled nursing or intermediate care facility services; home health services; private duty nursing; hospice care; physical therapy and related services; respiratory care; other diagnostic screening, preventive, and rehabilitative services; inpatient services for individuals over age 65 in institutions for mental diseases; and inpatient psychiatric care for children under 21. However, the State would be required to offer acute care Medicaid benefits in the same amount, duration, and scope as it offered those services to AFDC recipients, including hospital care; physician services; laboratory and x-ray services; early and periodic screening, diagnosis, and treatment services for children under 21; family planning services and supplies; dental care; prescribed drugs; nurse-midwife services; and case management. A State would not be required to offer a benefit to families qualifying for the 18-month extension that it did not offer to "categorically needy" families receiving cash assistance.

In addition to offering its regular Medicaid benefits (or an acute care Medicaid benefit package), a State could elect to offer families a choice of one or more alternative types of coverage during the 18-month extension period. Federal Medicaid matching payments would be available for the costs of providing these alternative types of coverage to the families who elect to enroll in them. The Committee stresses that whatever alternative a State elects to offer, the decision as to whether to continue receiving regular Medicaid benefits, or whether to enroll in an alternative type of coverage, is solely that of the family. The State could try to influence this choice by varying the premium levels among the types of coverage, subject to the limit of 10 percent of excess income, but it could not assign the family to a particular coverage.

The Committee amendment recognizes four generic alternatives that the States may offer to families: (1) enrollment in the family option of the group health plan, if any, offered by the mother's employer; (2) enrollment in the family option of the group health plan offered by the State to its own employees; (3) enrollment in a basic health plan, if any, offered by a State to the uninsured; or (4) en-

rollment in a health maintenance organization (HMO) fewer than half of whose enrollees are eligible for Medicaid. The State may offer one or more of these options, and it may offer different options in different parts of the State. The Committee notes that some States, under their regular Medicaid plans, offer AFDC families the choice of enrolling in an HMO or other prepaid plan; the HMO alternative in the Committee amendment would be in addition to, and not in lieu of, any prepaid health plan option that the State might offer under its Medicaid program.

The Committee amendment does not establish any minimum requirements for these alternative coverage options. The Committee intends that Federal Medicaid funds not be used to purchase coverage that is inadequate to meet the needs of working poor families or that is excessive in its cost. However, rather than attempting to restructure the health plan marketplace to achieve these objectives, the Committee amendment would rely on the judgment of the States in presenting coverage options and the judgment of families in choosing among them. The Committee is confident that, given the opportunity to make an informed choice between basic Medicaid coverage and any alternatives, the families will select the coverage that best meets their needs in a cost-effective manner.

As in the case of the initial 6-month extension, States would have the options of offering Medicaid "wrap-around" coverage to families who opted for Medicaid coverage during the 18-month extension period. This "wrap-around" coverage would be on the same terms as during the initial 6-month extension: the State could, as a condition of coverage, require the caretaker relative to enroll in her employer's group health plan; the State would have to meet all the employee's premium, deductible, coinsurance, and other requirements; and the State would treat the health plan as a third party liability, paying the amounts unsatisfied after the health plan paid except in the case of prenatal or preventive pediatric care. However, States that offered enrollment in an employer health plan as an alternative to the basic Medicaid benefit could not use Federal matching funds to provide Medicaid "wrap around" coverage to families who opted to enroll in their employer's plan. In the former case, "wrap around" coverage would be a cost-saving tool for the State, which would get the benefit of a third-party liability. In the latter case, "wrap around" coverage would distort the choice presented to the family between regular Medicaid coverage and enrollment in an employer health plan.

The Committee amendment would not place any limit on the premium, deductible, and other cost-sharing requirements which any of the alternative coverage options offered by the State might have. The amendment would, however, require the State to pay the full amount of any employee premiums or other enrollment costs on behalf of the family. These State costs (less any premium revenues from the families) would be subject to Federal matching payments at the State's regular matching rate. The State, in its notice of coverage options during the third and sixth month of extended Medicaid benefits, would have to inform families of the specific deductible and other cost-sharing requirements under the coverage options available to that family. With two exceptions, a family electing to enroll in an alternative type of coverage would be re-

sponsible for any deductibles, coinsurance, and similar types of cost-sharing other than premiums or enrollment costs. The State would have pay the deductible, coinsurance, and other cost-sharing requirements with respect to services related to pregnancy (including prenatal, maternity, and post-partum care) and with respect to ambulatory preventive pediatric care for children born on or after September 30, 1983.

Under the Committee amendment, during the 18-month extension period a State could elect to impose premiums on families and to offer coverage to those families in their employer group health plans. Depending on its income and child care costs, the family would have a monthly premium obligation, which it would pay directly to the State. The State, in turn, would pay the employee's required premium contribution directly to the employer or the employer's health plan. The family would not have any obligation to pay the employer any portion of the premium cost for enrollment in the employer's plan.

If a State chooses to offer one or more alternative types of coverage, the State would have to offer families an open enrollment period of one month each year during which families could enroll in, or disenroll from, an option without cause. The State would also have to give families the option of disenrolling, without cause, from a State basic uninsured plan or an HMO at any time.

The Committee amendment would provide five grounds for the termination of coverage during this 18-month extension period. First, coverage would terminate at the close of the first month in which the family no longer includes a child who is (or would if needy be) a dependent child for AFDC purposes. As in the case of the initial 6-month extension, a State could not discontinue coverage for the child until it had determined that the child was not eligible for Medicaid on some other basis under the State's Medicaid plan.

Second, if a State elects to require a premium contribution from the family, and if the family fails to pay the premium for a month by the 21st day of the following month, the extension coverage would terminate at the close of that following month, unless the caretaker relative establishes, to the satisfaction of the State, good cause for the failure to pay the premium on a timely basis. Good cause would include a sudden drop in income or increase in basic living costs that renders the family unable to make payment at the retroactively established premium rate.

Third, extension coverage would terminate if the caretaker relative had no earnings whatsoever in one or more of the previous three months, unless the lack of earnings was due to layoff or other involuntary loss of employment, to illness of the employee or family member, or to other good cause established to the State's satisfaction. The Committee intends that extension coverage during this 18-month period be limited to families in which the mother or other caretaker relative works. The Committee recognizes, however, that there will inevitably be cases where, for one or more months, the caretaker is unable to work due to circumstances beyond her control. Particularly in the low-wage, entry-level jobs where families moving off of welfare usually start, layoffs and even business failures are not uncommon. The Committee expects that

States, in administering this provision, will take full account of these realities.

Fourth, extension coverage would terminate if the family's average gross monthly earnings (less the costs of day care for dependent children) during the immediately proceeding three month period exceeds 185 percent of the Federal poverty income guideline for a family of that size, currently $1,434 per month for a family of 3. (The most recent update of the poverty income guidelines appears in the Federal Register for February 20, 1987 at page 5340). The Committee amendment would not allow a family with gross earnings (less day care costs) in excess of 185 percent of the poverty line to qualify for continued coverage by applying their medical expenses against income to "spend down" below 185 percent of the poverty level. A family with substantial medical expenses might, however, qualify for coverage as "medically needy" in a State which offered such coverage.

Fifth, extension coverage would terminate if the family fails to report information on its gross monthly earnings (less the costs of day care for dependent children) for each of the 3 previous months, unless the family establishes, to the satisfaction of the State, good cause for the failure to report on a timely basis. These reports would be due to the State by the 21st day of the 1st, 4th, 7th, 10th, 13th, and 16th months of the 18-month extension period. No termination could occur unless the State had notified the family, in the month before the month in which the information was due, of the reporting requirement. A State could, at its option, instead of terminating coverage for failure to report earnings in a timely fashion, provide for a suspension of coverage until the month after the month in which the family reports, so long as the family continued to have earnings in each month and so long as its earnings did not exceed the 185 percent of poverty ceiling. The Committee would expect that, in cases other than wilfull failures to report, States would suspend coverage until the report was filed, rather than terminate coverage altogether.

Other than the general prohibition against coverage of individuals whose cash assistance benefits were terminated due to fraud, these five grounds are the only reasons for which a State could terminate Medicaid coverage during the 18-month extension period. In no event could a State terminate coverage unless it has given the family written notice of the grounds for termination, including an explanation of the circumstances under which a family can request a pretermination fair hearing. In those cases where coverage would be terminated due to the failure of the caretaker relative to have any earnings in a month, the notice of termination must also include a description of how the family may reestablish eligibility for Medicaid. In States which offer coverage to the "medically needy," no family which still includes a dependent child could be terminated from extension coverage until the State has determined that the family does not have sufficient medical expenses to enable it to qualify for Medicaid as a "medically needy" family.

Under the Committee amendment, eligibility for this 18-month extension coverage depends on a family's earnings and child care expenses. In addition, the States have the option of charging a premium for coverage based on these factors. The Committee amend-

ment therefore establishes certain reporting requirements during both the initial 6-month extension period and the subsequent 18-month period to assure that the States have sufficient information about earnings and child care expenses to enable them to make eligibility determinations. The Committee expects that the States will administer these reporting requirements in a way that they do not become barriers to coverage for otherwise eligible families.

For example, under the Committee amendment, States would have to develop reporting forms, and provide the forms to families in the month prior to the month in which the report is due, along with information about the family's obligation to file and the effect of a failure to file or to file on time. The Committee expects that States will do whatever they can to encourage families to file early in the reporting period and that they will consider the use of reminder notices where reports have not been received by the midpoint of the period. Since the reporting form will only request as much information as the State needs to make its determinations with regard to eligibility and any premium amount, the Committee anticipates that States will be able to devise a short, simple form that they are able to process expeditiously. The Committee expects that States will take particular care to assure that the form can be understood by the population that will be receiving it. In addition, the form should be accompanied by a preaddressed return envelope so that it can be posted by the family as it is received. The timely filing of a reasonably completed form would be sufficient to meet the reporting requirement; the Committee does not expect that eligibility would be suspended or terminated if it is necessary for the State to seek clarification of the information supplied, to obtain verification, or to seek additional information. However, if the information supplied on the form is so deficient that it could not reasonably be construed to be a report of the family's earnings for the relevant period, and if the deficiencies are not attributable to the filer's limited comprehension or literacy, then suspension or termination of eligibility would be appropriate.

The process of reporting and eligibility determination under the Committee amendment can best be explained with the following example. Assume a mother and two children receiving AFDC and Medicaid benefits in March, April, and May of 1987. In June, 1987, the mother notifies her caseworker that she has found a job which begins in July. Despite the disregard of certain work-related expenses, child care expenses, and $30 and one-third of the remaining earned income, she will make enough at this job to disqualify her from AFDC in July because of the State's relatively low AFDC payment standard. In June, after receiving this information, the State sends her a notice that her AFDC benefits, and those of her children, will be terminated effective July 1st. The notice also includes a Medicaid care for the period July 1 through December 31. In September, the State, which will be charging a premium during the 18-month extension period but will not be offering alternative types of coverage, sends her a notice informing her of the 18-month extension and of her obligation to file a report on her earnings and child care expenses. By October 21, the mother sends back to the State its reporting form with information on the family's gross monthly earnings and child care expenses for July, August, and

September. The State uses this information to determine her eligibility for the 18-month extension coverage and to calculate her monthly premium for the January through March, 1988, period. In December, the last month of the initial 6-month extension, the State sends the mother another notice of the 18-month extension, including (1) the amount of her family's monthly premium for the first three months of the 18-month extension, (2) a Medicaid card for the months of January, February, and March of 1988, and (3) and a reporting form for earnings and child care costs for October, November, and December of 1987, specifying that it must be completed and returned to the State by January 21, 1988.

In early January, the first month of the 18-month extension, the mother files her report on earnings and child care costs for October, November, and December of 1987. She also includes her monthly premium for January, although she would have until February 21 to send it to the State. The State uses this earnings and child care information to determine whether the family continues to qualify for extension coverage for the April through June, 1988, quarter, and to calculate what the monthly premium during that period will be. In February, the State sends the mother a reminder that her premium for that month is due, and later that month, she sends in her premium payment. In March, the State sends the mother (1) a Medicaid card for April, May, and June, 1988, (2) the amount of her monthly premium during this period, (3) a reporting form for earnings and child care costs for January, February, and March of 1988, and (4) a reminder that her premium for March is due by April 21. The State will use the earnings and child care cost information to determine the family's eligibility for the July through September quarter, and to calculate the monthly premium during that period. In early April, the mother sends in the earnings report, as well as the premium for March. Later in April she receives a reminder notice from that State that her premium for that month is due. The process would continue in this manner until June of 1989, the last month of the 18-month extension, unless the family stopped paying the required premiums or was terminated from coverage on one of the other grounds identified in the Committee amendment.

Washington Family Independence Program Waiver.—The State of Washington has enacted legislation to establish a 5-year demonstration project, the Family Independence Program, as a budget-neutral alternative to the current AFDC program. A basic thrust of the project is to restructure current benefits so as to increase the incentives to work; this includes extending the current Medicaid transition period for families losing AFDC due to earnings from 4 months to 12 months. The State is seeking from the Federal government waivers of requirements of various programs, including Medicaid, to enable it to implement this demonstration.

Under the Committee amendment, if the Secretary of Health and Human Services approves a demonstration project relating to the Washington Family Independence Program, the Secretary is directed, with respect to such project, to waive compliance with the current Medicaid requirements relating to statewideness, beneficiary cost-sharing, and transitional Medicaid coverage for working welfare recipients (as established by the Committee amendment).

The Secretary has authority to waive the specified Medicaid requirements only to the extent necessary to enable the State to carry out the Family Independence Program (FIP) in the form in which it was enacted by the Washington State legislature on May 18, 1987. The Committee notes that section 20(4) of the FIP enabling legislation provides for amendments to that legislation. If any such changes are made, the authority of the Secretary under the Committee amendment would lapse, and any waivers that the Secretary might have been granted would be void.

The Committee's intent in authorizing these specific Medicaid waivers is that the State use the waivers to expand coverage, as set out in section 11 of the FIP enabling legislation. The Committee amendment does not authorize either the Secretary or the State to reduce benefits or coverage to individuals eligible to participate in the demonstration below the levels of the State's existing Medicaid program, including coverage and benefits authorized by the State legislature in its 1987 biennial budget. The Committee expects that any waiver of current cost-sharing rules would apply to those families participating in FIP only during the one-year extension of Medicaid benefits following the loss of cash assistance eligibility, and that no individual eligible to participate in the demonstration would pay more in copayments or premiums that he or she would have paid to receive benefits under the State's existing Medicaid program.

EXTENSION OF MEDICAID COVERAGE DUE TO COLLECTION OF SUPPORT

The Committee amendment requires States to extend Medicaid coverage for 6 months to families who lose AFDC benefits as a result, in whole or in part, of the collection or increased collection of child or spousal support, and who received AFDC benefits in at least 3 of the 6 months preceding the loss of eligibility for AFDC. This amendment has the effect of increasing the 4-month extended coverage period under current law to 6 months, a period consistent with the initial coverage for families losing AFDC due to earnings. States would not, however, be required to extend Medicaid to these families after the 6-month period, unless a family or the children in the family qualified for coverage on some other basis under the State's Medicaid plan.

HEARINGS

The Committee's Subcommittee on Health and the Environment held 1 day of hearings on the Medicaid transition provisions in H.R. 1720 on April 24, 1987. Testimony was received from 7 witnesses, including a representative of the Committee on Ways and Means, a former welfare recipient, and individuals representing the Governors and State Medicaid agencies.

COMMITTEE CONSIDERATION

On July 1, 1987, the Subcommittee on Health and the Environment met in open session and ordered reported the bill H.R. 1720, as amended, by a voice vote, a quorum being present. On July 21, 1987, the Committee met in open session and ordered reported the

bill H.R. 1720, with amendment by a recorded vote of 22 to 6, a quorum being present.

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

COMMITTEE ON GOVERNMENT OPERATIONS

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

COMMITTEE COST ESTIMATE

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the cost incurred by the Federal government in carrying out the Committee's amendment to H.R. 1720 would be $20 million in FY 1988, $120 million in FY 1989, and $250 million in FY 1990. These costs are in relation to current law. The Committee notes that, in relation to the amendment reported by the Committee on Ways and Means providing for a 6-month extension of Medicaid coverage to families that leave cash assistance with earnings, the cost of the Committee amendment is $20 million in FY 1988, $70 million in FY 1989, and $140 million in FY 1990. The Committee would also observe that to the extent the work incentives contained in the Committee bill are successful at keeping families employed and off of AFDC cash assistance, the Federal government will not incur costs for cash assistance to these working families.

CONGRESSIONAL BUDGET OFFICE ESTIMATE, JULY 22, 1987

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared this cost estimate for amendments to H.R. 1720, the Family Welfare Reform Act of 1987, as ordered reported by the House Committee on Energy and Commerce on July 21, 1987. H.R. 1720 was ordered reported by the House Committee on Ways and Means on June 10, 1987.

This estimate provides the spending impacts of the Committee on Energy and Commerce amendments to H.R. 1720. The table below shows the original estimate of H.R. 1720's impact on spending, the Committee on Energy and Commerce changes to spending, and the resulting estimated spending totals for the bill as amended.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Ways and Means bill:					
Budget authority/estimated authorization level	225	521	1,208	1,593	1,775
Estimated outlays	192	520	1,214	1,599	1,780
Energy and Commerce Amendments:					
Budget authority/estimated authorization level	20	70	140	170	190
Estimated outlays	20	70	140	170	190
Total spending:					
Budget authority/estimated authorization level	245	591	1,348	1,763	1,965
Estimated outlays	212	590	1,354	1,769	1,970

The Committee on Energy and Commerce amended the provision in H.R. 1720 that would provide Medicaid for six months to families who left the Aid to Families with Dependent Children (AFDC) program with earnings. The provision was amended in several important respects. First, the original bill would extend the additional months of Medicaid to all families who left with any earnings—an estimated 1.2 million families—while the amendments would extend Medicaid only to those who left AFDC because of increased earnings or hours of work—an estimated 0.5 million to 0.6 million families. The Energy and Commerce amendments also would extend Medicaid coverage for six months to families who left AFDC because of increased child support payments. Second, while the original bill would provide Medicaid to eligible families for 6 months after they left AFDC, the Energy and Commerce amendments would extend Medicaid eligibility to 24 months after leaving AFDC. Third, the amendments would give states a number of options in providing the required coverage, including the option to charge premiums after the sixth month. Finally, the effective date was moved up to January 1, 1988 from October 1, 1988. The net result of these changes would be to increase Federal costs by $20 million in fiscal year 1988 and by $190 million in fiscal year 1992, as shown in the preceding table.

CBO's estimate was calculated in two steps. The costs of providing the additional Medicaid—the basic benefits—were estimated first, ignoring the effects of any premiums. Then the effects of premiums on revenues and participation were estimated. Each step is discussed in turn.

Basic benefits: CBO estimates that the number of families who would receive the 24 months of Medicaid after leaving AFDC would be 500,000 to 550,000 each year after the program was fully effective (the provision would be delayed for states whose legislatures would not be in session until 1989). Some 1.9 million families leave AFDC each year (not counting those families who leave because their youngest child is too old to be eligible for AFDC). Based on data in a study by David Ellwood ("Working Off of Welfare: Prospects and Policies for Self-Sufficiency of Women Heading Families," Institute for Research on Poverty, Discussion Paper No. 803-86, March 1986) and on AFDC program statistics, CBO estimates that 25 percent of these families would leave AFDC because of in-

creased earnings or hours of work, making them eligible for the transition benefits. This estimate was increased by the number of families who were estimated to leave AFDC because of the bill's work and training program and by the number of new two-parent families leaving AFDC each year with the bill's mandating of the AFDC-Unemployed Parent program in all states. Another 40,000 to 45,000 families are estimated to leave AFDC each year because of increased child support payments.

Medicaid costs for these families would depend on whether they had private health insurance through their jobs or from some other source. Based on data from the Current Population Survey—a household survey of the Bureau of the Census—CBO estimates that 55 percent of the families leaving AFDC because of increased earnings and 45 percent of those leaving because of child support would have access to health insurance. Data do not exist on Medicaid costs for those with private health insurance. CBO assumes that 85 percent of these families would retain Medicaid (at least until the premium is due) and that their Medicaid costs would be one-third of "full" costs. Federal Medicaid costs per family (for those without health insurance) are estimated to be $1055 in 1988 and $1425 in 1992, amounts for "healthy" families. Costs are reduced to account for recidivism; adjustments of 91 percent, 77 percent, 70 percent, 66 percent, and 62 percent are made for the first through fifth years, respectively.

Current-law Medicaid costs for families leaving AFDC are subtracted from the costs of extending Medicaid for 24 months (or for 6 months to the child support families). Under current law, those who leave because their hours of work or their earnings increase receive Medicaid for four months, as do families with increased child support payments. (Those who leave because they lose the $30 and one-third earnings disregard after they have worked for four or twelve months receive Medicaid for nine months and at state option for another six months, but there would be no more of these families because H.R. 1720 would make the earnings disregard permanent.) Further, some families qualify for Medicaid under medically-needy provisions. For purposes of this estimate, CBO calculated that 35 percent would qualify for medically-needy benefits after their regular Medicaid benefits were exhausted. Current-law costs are increased slightly to account for legislation in recent years that extended Medicaid to low-income pregnant women and young children, and are reduced to allow for recidivism. Federal costs of the basic benefits before any premium offsets are estimated to rise from $20 million in 1988 to $400 million in 1992.

Premium offsets: Estimated premium collections rest on two basic assumptions: the average premiums that would be set by the states and the participation rates of families who would be required to pay the premiums. Some 20 percent of eligible families are estimated to have the premium waived because of the legislated limit, which is 10 percent of the difference between the eligible family's gross monthly income (less day care costs) and the monthly minimum wage. For the remaining 80 percent, CBO assumes that states would generally apply premiums that would increase with family incomes and that most states would set premiums near or at the maximum allowable. Incomes of families after stays on

AFDC were estimated from Ellwood (op. cit.). Thus, the total amount of premium revenue is estimated to amount to roughly two-thirds of the maximum allowable (for those assumed willing to pay), which is equivalent to about 1 percent to 3 percent of gross incomes in the income ranges above the minimum wage. The resulting monthly premiums of $7 to $33 per month are estimated to generate collections which would offset less than 10 percent of the costs incurred from participation. In the aggregate, premiums to the Federal government are estimated to rise from an insignificant amount in 1988 to $25 million in 1922.

In addition to generating revenues, premiums are likely to deter some eligible families from acquiring this extended Medicaid benefit. Those who would choose not to pay the premium would lose eligibility and generate no program costs. This effect was calculated separately for those with health insurance and those without health insurance, since it is reasonable to assume very different behavior in these two groups. There is little evidence on this question, and CBO assumes that of those without health insurance, about 65 percent would choose to maintain Medicaid eligibility in return for a modest premium payment, and 15 percent would not (the remaining 20 percent would not have to pay any premiums). For those with health insurance, CBO assumes that only about 15 percent would choose to pay the premium. An important foundation for this latter assumption is the amendment's stipulation that payment of the premium would not obligate Medicaid to pay for the eligible family's deductible and coinsurance under the primary insurance. Moreover, CBO assumes that Medicaid benefits would not be significantly better than most of the health insurance policies to which it would be secondary payer. Further, CBO assumes that those families choosing to pay the premium would have higher medical care costs, on average, than those who would not pay the premium.

State costs: Because states pay about 45 percent of the costs of Medicaid in the aggregate, their budgets would also be affected by the Energy and Commerce amendments. As shown in the table below, the amendments would increase costs of states and localities by $20 million in 1988 and $160 million in 1992.

ESTIMATED COST TO STATE AND LOCAL GOVERNMENTS

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Ways and Means bill	141	201	345	371	272
Energy and Commerce amendments	20	55	115	135	160
Total cost	161	256	460	506	432

If you wish further details on this estimate, please call me or have your staff contact Alan Fairbank or Janice Peskin (226-2820).

With best wishes,

Sincerely,

EDWARD M. GRAMLICH,
Acting Director.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill. The Committee believes that the bill will not have an inflationary impact on prices and costs in the economy. By eliminating one of the major work disincentives for poor families on welfare, the Committee bill will encourage more low-income women to work and thereby increase the economy's productive capacity.

Agency Views

The Secretary of Health and Human Services,
Washington, DC, July 13, 1987.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.

Dear Mr. Chairman: I would like to take this opportunity to inform you of the Department's views on Title IV of H.R. 1720, the Medicaid provisions of the "Family Welfare Reform Act of 1987", as approved by your Committee's Subcommittee on Health and the Environment. The Subcommittee approved, as Title IV of H.R. 1720, provisions based upon H.R. 2627, the "Family Medicaid Reform Amendments of 1987", on which we have previously expressed our views to Chairman Waxman.

Title IV of the bill would now require States to provide a six-month extension of Medicaid coverage under title XIX of the Social Security Act (subject to certain continuing eligibility requirements) to families who had received cash assistance under the Aid to Families with Dependent Children (AFDC) program for three of the preceding six months, and left the AFDC rolls because of increased earnings. It would further require States to offer, to families that had received Medicaid for a full six months of extended eligibility, an additional 18 months of Medicaid coverage or, at State option, any of several other specific types of health care coverage for that period, unless a family's average gross monthly earnings for a three-month period (after deducting the costs of day care for dependent children) exceeded 185 percent of the Federal poverty level; the family failed to pay a small premium (if the State chose to require premiums); or any of several other circumstances occurred. States would then have the option of extending health care coverage for an additional 18 months under the same conditions. Title IV would also increase for four to six months the current Medicaid extension for those leaving the AFDC rolls as a result of increased child support.

In summary, the Administration strongly opposes Title IV. Substantial Medicaid transitional benefits already are available to welfare recipients, and there is no convincing evidence that their expansion would reduce welfare dependency. We are pleased to see that some of the costly and complex new administrative requirements, to which we objected in our report on H.R. 2627, have been eliminated or at least made optional for the States. However, other features remain or have been added which have the potential for

driving the States to cut benefits for those now eligible for Medicaid and severely constraining their capacity to take advantage of optional Medicaid coverage provisions which primarily benefit pregnant women, infants, children, the elderly and families with high medical expenses. Rather than reducing welfare dependency, Title IV of H.R. 1720 is likely to increase it, at great human and financial cost to our Nation. A preliminary estimate indicates that, when fully implemented in FY 1992, Title IV would cost the Federal Government nearly $1 billion, and would substantially increase State costs as well.

Current law already provides for four months of additional Medicaid coverage for families that leave the AFDC rolls as a result of increased earnings or child support. Up to 15 months of Medicaid coverage is provided to families who leave AFDC because of expiration of the earned income disregard. In addition, there are a variety of other arrangements, including Medicaid medically needy coverage and Community Health Center programs, available to address the health care needs of low-income families and individuals whose employment does not provide health insurance coverage.

There is no evidence that expanding the current Medicaid transitional provisions would be cost-effective, get more people into jobs and off the welfare rolls, or produce welfare savings. Indeed, there is evidence to suggest that Medicaid coverage is not a critical factor in employment decisions. The changes made by the Omnibus Budget Reconciliation Act of 1981 (OBRA) established income ceilings on AFDC eligibility for working families, many of whom appear to have been long-term welfare recipients. No transitional Medicaid coverage was provided at that time; and if such coverage were a key factor in families' employment decisions, one would expect that many of these families would have quit work and returned to the welfare rolls. However, the rate of return for families with earnings was no greater after OBRA than it was before, suggesting that Medicaid was not a key factor in their job decisions. Given the lack of evidence that any changes are needed, we cannot justify the costs of providing the proposed additional coverage.

While we are not persuaded that Medicaid coverage actually operates as a key factor in employment decisions, in cases where it might be a factor this bill would exacerbate welfare dependency. Title IV might well induce families who otherwise would leave the welfare rolls in less than three months to remain on the rolls to receive up to three and a half years of publicly subsidized medical coverage. Moreover, families might be induced onto the AFDC rolls simply to receive this coverage, and employers would have significant incentives not to offer or even to cut back on health insurance coverage for lower wage workers.

We have heard from a number of States that are deeply concerned about the numerous administrative complexities and costs of implementing Title IV, and we share their concerns. A new, costly and complex administrative structure would have to be created by States to compute income eligibility for these new Medicaid extensions. Another such structure would have to be created by any State choosing to collect premiums during the 18-month extensions. (While States have for some time been permitted to collect income-related co-payments, deductibles, and co-insurance from

Medicaid beneficiaries, few if any have chosen to do so because of the cost and complexity of such a process.) Similarly, any State choosing to use the wrap-around option or any of the other four options for health insurance coverage applicable during the 18-month extensions would have to establish an administrative structure to pay the premiums and deal with the various entities administering the health plans.

Two new features of Title IV, as approved by the Subcommittee, also give reasons for serious concern. First, termination of extended Medicaid eligibility for failure to pay premiums or to make quarterly income reports, or for lack of earnings, have been made subject to "good cause" exceptions. This could be a major administrative burden, and could well result in court challenges. Second, the costs of day care for dependent children must be subtracted from a family's earnings before determining whether earnings exceed 185 percent of the Federal poverty line (thus making the family ineligible) or whether payment of a premium is required (in States electing that option). The net result would be to keep more people eligible for a longer period and to have fewer subject to payment of a premium, thus driving up costs.

The expensive new provisions in Title IV could well force some States to cut back on the Medicaid coverage they now provide. Moreover, these provisions would greatly constrain States' ability to expand Medicaid under optional coverage authorities now in law. States, for example, now have the latitude to extend Medicaid coverage to pregnant women, infants and children up to age 5 in families whose income is below the Federal poverty line. By mandating coverage for former welfare recipients, Title IV of H.R. 1720 would greatly curtail States' ability to take advantage of this and other optional coverage provisions.

As part of his multifaceted welfare strategy, the President has clearly stated his strong commitment to welfare reform legislation that provides authority for State- and community-based demonstrations to test alternatives for restructuring our Nation's welfare system. We remain convinced that this approach would be more effective for families, and more prudent administratively and fiscally, than the approaches proposed in H.R. 1720. H.R. 1288, the "Low-Income Opportunity Improvement Act," proposed by the Administration, would encourage such State-sponsored and community-based demonstration projects to test innovative welfare system alternatives which could include Medicaid features.

I urge you to reconsider the direction in which this legislation is heading and to consider instead passage of H.R. 1288, which would permit States to test a variety of cost-effective approaches to achieving the goal of encouraging family self-sufficiency.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report, and that enactment of H.R. 1720 would not be in accord with the program of the President.

Sincerely,

OTIS R. BOWEN, M.D.,
Secretary.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by title IV of the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) * * *

* * * * * * *

[(e)(1) Nothwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.]

(e)(1)(A) For provision relating to extension of coverage for certain families which have received aid pursuant to a State plan approved under part A of title IV and which have earned income, see section 1921.

(B) Notwithstanding any other provision of this title, each dependent child, and each relative with whom such a child is living (as such terms are defined in part A of title IV, and including the spouse of such a relative as described in section 406(b)), who—

(i) becomes ineligible for aid under part A of title IV as a result (wholly or partly) of the collection or increased collection of child or spousal support under part D of such title, and

(ii) has received such aid in at least three of the six months immediately preceding the month in which such ineligibility begins,

shall be deemed, for purposes of this title, to be a recipient of aid under part A of title IV for an additional 6 calendar months beginning with the month in which such ineligibility begins.

* * * * * * *

(h)(1) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs.

(2) Nothing in section 417(a)(1) shall be construed as requiring or authorizing a case manager assigned under such section to conduct any activities with respect to medical assistance furnished (or which may be furnished) under this title.

(3) Any individual who would be receiving aid under part A of title IV but for section 417(b)(1)(A) shall be considered, for purposes of this title to be receiving such aid.

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary [81-3]) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or part of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) * * *

* * * * * * *

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title VXI, [or]

(viii) pregnant women, *or*

(ix) individuals provided extended benefits under section 1921,

* * * * * * *

EXTENSION OF MEDICAID BENEFITS

SEC. 1921. (a) INITIAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which

such family becomes ineligible for such aid, because of hours of, or income from employment of the caretaker relative (as defined in subsection (e)), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

(2) NOTICE OF BENEFITS.—Each State, in the notice of termination of aid under part A of title IV sent to a family meeting the requirements of paragraph (1)—

(A) shall notify the family of its right to extended medical assistance under this subsection and include in the notice a description of the circumstances (described in paragraph (3)) under which such extension may be terminated; and

(B) shall include a card or other evidence of the family's entitlement to assistance under this title for the period provided in this subsection.

(3) TERMINATION OF EXTENSION.—

(A) NO DEPENDENT CHILD.—Subject to subparagraph (B), extension of assistance during the 6-month period described in paragraph (1) to a family shall terminate (during such period) at the close of the first month in which the family ceases to include a child who is (or would if needy be) a dependent child under part A of title IV; except that, with respect to a child who would cease to receive medical assistance because of this subparagraph but who may be eligible for assistance under the State plan because the child is described in clause (i) or (v) of section 1905(a), the State may not discontinue such assistance under this subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination.

(4) SCOPE OF COVERAGE.—

(A) IN GENERAL.—Subject to subparagraph (B), during the 6-month extension period under this subsection, the amount, duration, and scope of medical assistance made available with respect to a family shall be the same as if the family were still receiving aid under the plan approved under part A of title IV.

(B) STATE MEDICAID "WRAP-AROUND" OPTION.—A State, at its option, may pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by a employer of the caretaker relative or the absent parent of a dependent child. In the case of such coverage offered by an employer of the caretaker relative—

(i) the State may require the caretaker relative, as a condition of extension of coverage under this subsection, to make application for such employer coverage, but only if—

(I) the caretaker relative is not required to make financial contributions for such coverage (whether through payroll deduction, payment of deductibles, coinsurance, or similar costs, or otherwise), and

(II) the State provides, directly or otherwise, for payment of any of the premium amount, deductible, coinsurance, or similar expense that the employee is otherwise required to pay; and

(ii) the State shall treat the coverage under such an employer plan as a third party liability (under section 1902(a)(25)).

Payments for coverage under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.

(b) MANDATORY 18-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B), in the last month of the period the option of extending coverage under this subsection for the succeeding 18-month period, subject to paragraph (3).

(2) NOTICE OF OPTION.—

(A) IN GENERAL.—Each State, during the 3rd and 6th month of any extended assistance furnished to a family under subsection (a), shall notify the family of the family's option for subsequent extended assistance under this subsection. Each such notice shall include (i) a statement as to whether any premiums are required for such extended assistance, and (ii) a description of other out-of-pocket expenses, benefits, reporting and payment procedures, and any pre-existing condition limitations, waiting periods, or other coverage limitations imposed under any alternative coverage options offered under paragraph (4)(D).

(B) REPORTING OF EARNINGS REQUIRED TO DETERMINE ANY PREMIUM.—If the State requires a premium for extended assistance under this subsection, the State may require (as a condition for extended assistance under this subsection) that a family receiving extended assistance under subsection (a) report to the State, not later than the 21st day of the 4th month in the period of extended assistance under subsection (a), on the family's gross monthly earnings (less the cost of day care for dependent children) in each of the first 3 months of that period; but such requirement shall only apply if the notice under subparagraph (A) during the 3rd month of assistance describes the requirement of this subparagraph.

(C) 6TH MONTH NOTICE.—The notice under subparagraph (A), furnished during the 6th month of assistance under this subsection, shall describe the amount of any premium required of a particular family for each of the first 3 months of extended assistance under this subsection.

(3) TERMINATION OF EXTENSION.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), extension of assistance during the 18-month period described in paragraph (1) to a family shall terminate (during the period) as follows:

(i) NO DEPENDENT CHILD.—The extension shall terminate at the close of the first month in which the family ceases to include a child who is (or would if need be) a dependent child under part A of title IV.

(ii) FAILURE TO PAY ANY PREMIUM.—If the family fails to pay any premium for a month under paragraph (5) by the 21st day of the following month, the extension shall terminate at the close of that following month, unless the individual has established, to the satisfaction of the State, good cause for the failure to pay such premium on a timely basis.

(iii) QUARTERLY INCOME REPORTING AND TEST.—The extension shall terminate at the close of the 1st, 4th, 7th, 10th, 13th, or 16th month of the 18-month period if—

(I) the family fails to report to the State, by the 21st day of such month, information on the family's gross monthly earnings (less the costs of day care for dependent children) in each of the previous 3 months, unless the family has established, to the satisfaction of the State, good cause for the failure to report on a timely basis; except that this subclause shall not apply unless the State has notified the family, in the month before the month in which information is required to be reported under this subclause, of the reporting requirement of this subclause;

(II) the caretaker relative had no earnings in one or more of the previous 3 months, unless such lack of any earnings was due to an involuntary loss of employment, illness, or other good cause, established to the satisfaction of the State; or

(III) the State determines that the family's average gross monthly earnings (less costs of day care for dependent children) during the immediately preceeding 3-month period exceeds 185 percent of the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

Instead of terminating a family's extension under clause (I), a State, at its option, may provide for suspension of the extension until the month after the month in which the family reports information required under that subclause, but only if the family's extension has not otherwise been terminated under subclause (II) or (III).

Information described in clause (iii)(I) shall be subject to the restrictions on use and disclosure of information pro-

vided under section 402(a)(9). The State shall make determinations under clause (iii)(III) for a family each time a report described in clause (iii)(I) for the family is received.

(B) NOTICE BEFORE TERMINATION.—No termination of assistance shall become effective under subparagraph (A) until the State has provided the family with notice of the grounds for the termination, which notice shall include (in the case of termination under subparagraph (A)(iii)(II), relating to no continued earnings) a description of how the family may reestablish eligibility for medical assistance under the State plan.

(C) CONTINUATION IN CERTAIN CASES UNTIL REDETERMINATION.—

(i) DEPENDENT CHILDREN.—With respect to a child who would cease to receive medical assistance because of subparagraph (A)(i) but who may be eligible for assistance under the State plan because the child is described in clause (i) or (v) of section 1905(a), the State may not discontinue such assistance under such subparagraph until the State has determined that the child is not eligible for assistance under the plan.

(ii) MEDICALLY NEEDY.—With respect to an individual who could cease to receive medical assistance because of clause (ii) or (iii) of subparagraph (A) but who may be eligible for assistance under the State plan because the individual is within a category of person for which medical assistance under the State plan is available under section 1902(a)(10)(C) (relating to medically needy individuals), the State may not discontinue such assistance under such subparagraph until the State has determined that the individual is not eligible for assistance under the plan.

(4) COVERAGE.—

(A) IN GENERAL.—During the extension period under this subsection—

(i) the State plan shall offer to each family medical assistance which (subject to subparagraphs (B) and (C)) is the same amount, duration, and scope as would be made available to the family if it were still receiving aid under the plan approved under part A of title IV; and

(ii) the State plan may offer alternative coverage described in subparagraph (D).

(B) ELIMINATION OF MOST NON-ACUTE CARE BENEFITS.—At a State's option and notwithstanding any other provision of this title, a State may choose not to provide medical assistance under this subsection with respect to any (or all) of the items and services described in paragraphs (4)(A), (6), (7), (8), (11), (13), (14), (15), (16), (18), (20), and (21) of section 1905(a).

(C) STATE MEDICAID "WRAP-AROUND" OPTION.—At a State's option, the State may elect to apply the option described in subsection (a)(4)(B) (relating to "wrap-around" coverage) for families electing medical assistance under this

subsection in the same manner as such option applies to families provided extended medical assistance under subsection (a).

(D) ALTERNATIVE ASSISTANCE.—At a State's option, instead of the medical assistance otherwise made available under this subsection the State may offer families a choice of health care coverage under one of more of the following:

(i) ENROLLMENT IN FAMILY OPTION OF EMPLOYER PLAN.—Enrollment of the caretaker relative and dependent children in a family option of the group health plan offered to the caretaker relative.

(ii) ENROLLMENT IN FAMILY OPTION OF STATE EMPLOYEE PLAN.—Enrollment of the caretaker relative and dependent children in a family option within the options of the group health plan or plans offered by the State to State employees.

(iii) ENROLLMENT IN STATE UNINSURED PLAN.—Enrollment of the caretaker relative and dependent children in a basic State health plan offered by the State to individuals in the State (or areas of the State) otherwise unable to obtain health insurance coverage.

(iv) ENROLLMENT IN HMO.—Enrollment of the caretaker relative and dependent children in a health maintenance organization (and defined in section 1903(m)(1)(A)) less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of enrollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a health maintenance organization in accordance with section 1903(m).

If a State elects to offer an option to enroll a family under this subparagraph, the State shall pay any premiums and other costs for such enrollment imposed on the family. A State's payment of premiums for the enrollment of families under this subparagraph (not including any premiums otherwise payable by an employer and less the amount of premiums collected from such families under paragraph (5)) shall be considered, for purposes of section 1903(a)(1), to be payments for medical assistance.

(E) OPEN ENROLLMENT.—If a State offers an alternative option under subparagraph (D) to families, the State must offer such families the option of enrolling or disenrolling in such an option during a one month period each year without cause and, in the case of enrollment under clause (iii) or (iv) of such subparagraph, the option of disenrolling from the organization or plan for cause at any time.

(F) PROHIBITION ON COST-SHARING FOR MATERNITY AND PREVENTIVE PEDIATRIC CARE.—

(i) IN GENERAL.—If a State offers an alternative option under subparagraph (D) for families, under the

option the State must assure that care described in clause (ii) is available without charge to the families through—

(I) payment of any deductibles, coinsurance, or other cost-sharing respecting such care, or

(II) providing coverage under the State plan for such care without any cost-sharing, or any combination of such mechanisms.

(ii) CARE DESCRIBED.—The care described in this clause consists of—

(I) services related to pregnancy (including prenatal, delivery, and postpartum services), and

(II) ambulatory preventive pediatric care (including ambulatory early and periodic screening, diagnosis, and treatment services under section 1905(a)(4)(b)) for each child who meets the age and date of birth requirements to be a qualified child under section 1905(n)(2).

(5) PREMIUM.—

(A) PERMITTED.—Notwithstanding any other provision of this title (including section 1916), a State may impose a premium for a family for extended coverage under this subsection, which premium may vary by family size.

(B) LEVEL MAY VARY BY OPTION OFFERED.—The level of such premium may vary, for the same family, for each option offered by a State under paragraph (4)(C).

(C) LIMIT ON PREMIUM.—In no case may the amount of any premium under this paragraph for a family for a month in one of the premium payment periods described in subparagraph (D)(ii) exceed 10 percent of the amount by which—

(i) the family's average gross monthly earnings (less the costs of day care for dependent children) during the premium base period (as defined in subparagraph (d)(iii)), exceeds.

(ii) the monthly minimum wage earnings (as defined in subparagraph (d)(i)) for the period.

(D) DEFINITIONS.—In subparagraph (C):

(i) The term "monthly minimum wage earnings" means the average amount of earnings which one person would earn during a month in the period if the person were employed for 8 hours on each weekday in the month and was paid the minimum wage rate provided under section 6(a) of the Fair Labor Standards Act of 1938.

(ii) A "premium payment period" described in this clause is a 3-month period beginning with the 1st, 4th, 7th, 10th, 13th, or 16th month of the 18-month extension period provided under this subsection.

(iii) The term "premium base period" means, with respect to a particular premium payment period, the period of 3 consecutive months the last of which is 4 months before the beginning of that premium payment period.

(c) APPLICABILITY IN STATES AND TERRITORIES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a), the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

(2) INAPPLICABILITY IN COMMONWEALTHS AND TERRITORIES.—The provisions of this section shall only apply to the 50 States and the District of Columbia.

(d) GENERAL DISQUALIFICATION FOR FRAUD.—This section shall not apply to an individual who is a member of a family if the individual's eligibility for aid was terminated because of fraud or the imposition of a sanction.

(e) CARETAKER RELATIVE DEFINED.—In this section, the term "caretaker relative" has the meaning of such term as used in part A of title IV.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1921.] *1922.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

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ADDITIONAL VIEWS OF REPRESENTATIVES JIM SLATTERY AND JIM COOPER ON THE FAMILY WELFARE REFORM ACT OF 1987

Our welfare system has long needed an overhaul, and we strongly support the Family Welfare Reform Act of 1987. H.R. 1720 will build into our welfare policies incentives for recipients to move toward economic independence. This legislation will encourage families to stay together and will see that the heads of these families get the education and training they need to leave welfare behind.

There is no question that reforming our welfare system will be costly. As we embark on an expansion of an entitlement program, we need to proceed with caution. According to Congressional Budget Office cost estimates, H.R. 1720 as reported by the Ways and Means Committee will cost the federal government $5.3 billion over five years. The bill will impose significant spending increases on the states as well. Nevertheless, the costs of perpetuating the dependence of millions of poor individuals on welfare are even greater.

The availability of health care coverage is an important component of a national strategy to assist dependent families in moving toward self-sufficiency. We believe that the Energy and Commerce six-month extension of Medicaid benefits, coupled with the additional eighteen-month alternative health protection policy, will be a vast improvement over the current four-month extension period. It is also significantly better than the six-month extension as reported by the Ways and Means Committee. The Committee's package of state options is innovative and may offer a partial solution to the problem of who should provide health insurance to the millions of Americans who lack it.

The Committee's extension of health care benefits to welfare families who find employment may enhance greatly our ability to assist welfare recipients in becoming productive partners in our country's economy. We appreciate Chairman Waxman's willingness to modify Title IV of the legislation, as originally reported by the Health and Environment Subcommittee, to ensure truly bipartisan support for this landmark legislation.

DISSENTING VIEWS ON H.R. 1720—FAMILY WELFARE REFORM ACT OF 1987

This Committee's jurisdiction over H.R. 1720 is limited to Title IV, which provides and extension of Medicaid benefits to individuals who come off of the welfare rolls. As reported by the Committee, Medicaid benefits would have to be provided for a total of 24 months after an individual became ineligible for welfare benefits because of increased earnings.

We are committed to preventing former recipients from returning to their dependence on welfare programs. We recognize that the rationale for the provision in Title IV is based on the belief that individuals will return to welfare, at least in part, because they need the health insurance coverage provided through Medicaid programs which they cannot obtain at reasonable costs as new employees. But we think that the provisions in Title IV which were reported by the Committee will increase, rather than decrease, dependency of Federal and State governments.

We believe that if the Committee's version of Title IV were enacted, families may be induced to stay on welfare rolls in order to receive 24 months of post-welfare health coverage. Additionally, employers may have an incentive to not offer or to reduce health insurance coverage for lower wage workers if they know Medicaid will provide coverage to former welfare recipients.

We are also concerned that the provisions in Title IV may force financially strapped States to cut back on Medicaid coverage they currently provide. States' abilities to provide optional coverages for pregnant women, infants, and children may be severely limited if they are required to provide 24 months of mandatory coverage to individuals coming off welfare.

Federal law currently provides for 4 to 15 months of Medicaid coverage for individuals who leave the welfare rolls. We believe that current law is sufficient to provide for a manageable transition from welfare dependency to self sufficiency.

Finally, we are concerned that the Congressional Budget Office estimates that the cost of providing Medicaid coverage for persons coming off of welfare will be one billion dollars over five years.

That is the Federal Government's share. The States will have to pay an equal amount over the same period. This is an exorbitant amount which neither level of government can currently absorb.

NORMAN F. LENT.
CARLOS J. MOORHEAD.
BILL DANNEMEYER
THOMAS J. TAUKE.
DON RITTER.
JACK FIELDS.
MICHAEL G. OXLEY.
HOWARD C. NIELSON.
MICHAEL BILIRAKIS.
DAN SCHAEFER.
JOE BARTON.
SONNY CALLAHAN.

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